Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR-0005	A. BUILDING _____ B. WING _____	C 07/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYE ASSISTED LIVING SERVICES	5131 CALL PLACE SE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments An investigation was conducted at your facility on July 21, 2010 following an incident report sent to the Department of Health on June 1, 2010 in reference to the death of a resident. Through record reviews and staff interviews, it was revealed that the facility followed proper protocol and procedures as it related to sending the resident to the emergency room on May 23, 2010 prior to her death on May 24, 2010. At the time of this investigation, the facility was in compliance with Assisted Living Law "DC Code § 44-101.01."	R 000		

Health Regulation Administration

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE